California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
June 9, 2008

The meeting was called to order by Vito Genna, Chair, at approximately 10:00 a.m., at the Marriot Hotel, Long Beach. A quorum of the members was in attendance.

Present:

Vito J. Genna, Chairperson
Jerry Royer, MD, MBA
Marjorie Fine, MD
Janet Greenfield, RN
Sonia Moseley, CANP
Reza Karkia, DBA
Adama Iwu
Joe Corless, MD, FAAP

Absent:

Corinne Sanchez, Esq.
William Brien, MD

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Staff Counsel; John Kriege, Acting Deputy Director, Healthcare Information Division; Patrick Sullivan, Assistant Director, Legislative and Public Affairs; Joseph Parker, PhD, Director of Healthcare Outcomes Center; Jonathan Teague, Manager, Healthcare Information Resource Center; John Gillengerten, Deputy Director, Facilities Development Division; Starla Ledbetter, Data Management Office; Robyn Strong, Associate Governmental Program Analyst, Healthcare Information Division; Mary Tran, PhD, Research Scientist, Retired Annuitant

Others Present: Pamela Lane, Vice President, Health Informatics

Chairperson's Report: Vito Genna, Chair

Chairperson Genna stated that if the current budget crisis is not resolved in a timely fashion there will be a significant impact on hospitals and long-term care relating to Medi-Cal payments and cash flow through the summer.

Chairperson Genna stated that he has asked Acting Deputy Director John Kriege to update the web-based trends report on long-term care. The trend report is a ten

year report that looks at admissions and discharges in long-term care. This report indicates that we have 5% fewer deaths in long-term care than 10 years ago. The report does not lend analysis to the figures, but the figures are certainly important for healthcare policy.

Recently there has been a lot of discussion on pay-for-performance on the hospital side and now, taking that one step further, Medicare has decided not to pay for never events as of October. These never events are situations that should not happen, for example, bed sores or surgeries where something is left in the patient. Medicare has said, 'We are not going to pay for that.' At this point Medi-Cal has made no decision on this issue.

There is a certain amount of ambivalence from the long-term care side; certainly for the consumers we need this, as it will change behavior with regard to safety measures in hospitals, but this will call for stringent documentation at the long-term care facility on the condition of the patient before sending them to the hospital.

Commissioner Greenfield asked for clarification on what Medicare will actually pay for. Chairperson Genna stated that, "according to an article in Modern Healthcare, if there are other diagnoses Medicare will continue to pay for them, but any care related to the never events will not be covered."

Commissioner Fine added that the problem with this issue is that many of the never events listed are unavoidable, for example, wound infection related to joint replacement, reconstructive procedures with hardware, or prosthetics. "Wound infections or prosthetic infections do not usually manifest themselves for weeks or months. The cost for caring for that individual should not be carried by the facility to which they are readmitted and many times they do not go back to the same facility or physician group. And these infections lead to other problems; the infected prosthesis leads to an infected heart valve. I don't see how you end this process of 'we're not paying.' The hospital coders will have problems with this as well, possibly leading to down coding on things that will trigger nonpayment. I think it will end up in the legal system. "

Chairperson Genna agreed, stating "Just from the court side, if Medicare is saying we are not paying for it because you did something wrong, that patient may have a civil case of wrong doing automatically."

Commissioner Royer added that certainly much has to be worked out relating to this matter but it definitely underscores the critical nature of 'present on admission'.

Approval of Minutes: A motion was made by Commissioner Fine and seconded by Commissioner Karkia to approve the minutes of the April 25, 2008 meeting. The motion was carried.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

Michael Rodrian has retired from the state after 30 years of service. For the last three years Michael Rodrian has worked at OSHPD as the Deputy Director of the Health Information Division (HID).

John Kriege has stepped in as the Acting Deputy Director of HID while recruitment goes on to fill the position.

Healthcare Reform continues to go forward in the form of 2.0. As the first step of 2.0, items that are fairly easy to implement without a major fiscal impact are going forward. The second step will be fiscally generated with the target of universal healthcare for Californians, but that is a more prolonged process.

California is facing a 17 billion dollar budget deficit and the state's economic climate is not supporting reducing this deficit. The Governor, recognizing the impact on a variety of social services programs that are dependent on the general fund, has asked the departments to do as much as they can to support the closure of the deficit. OSHPD has proposed loans of 23 million dollars to the general fund deficit and these loans will not affect the operational programs that are supported by the special funds.

California will probably enter the new fiscal year without a budget as indicated by the historic precedent.

Legislative Update: Patrick Sullivan, Assistant Director, Legislative and Public Affairs

AB 2966 (Lieber) requires OSHPD to assume the responsibility of employing all hospital Inspector of Record (IOR), rather than the current method whereby the hospital governing board or authority that is funding the project is required to obtain the services of the IOR. OSHPD opposes this bill due to flaws in the language.

AB 3028 (Salas) authorizes OSHPD to implement new processes and technologies that would expedite the plan review and construction of hospital design projects. This bill may be amended to potentially address economic stimulus in terms of hospital construction. This bill is expected to pass.

AB 2375 (Hernandez) establishes a Health Professions Workforce Task Force to develop a health professions workforce master plan for the state.

AB 2942 (Ma) overhauls and standardizes California's hospital community benefits reporting purpose and structure by requiring all hospitals in California to report on and provide community benefits as a condition of licensure; requiring the creation of hospital mission statements, needs assessments, and community benefits plans in collaboration with stakeholders, public agencies, and community groups with reliance on local health data; and specifying the contents of hospital community benefits plans, methodology and documentation of plan completion.

AB 2967 (Lieber) establishes a Health Care Cost and Quality Transparency Committee to develop and recommend to the Secretary of Health and Human Services a health care cost and quality transparency plan. This would establish the Health Care Cost and Quality Transparency Committee housed at Health and Human Services relying largely on the functions of OSHPD to implement that. The initial task of the Committee would be to come up with a plan to identify healthcare costs and look at quality. Some functions of

that Committee may overlap the functions of the Commission but that has not been addressed in the legislation yet.

AB 2439 (De La Torre) requires the Medical Board to collect a mandatory $50 fee from physicians and surgeons at the time of licensure or biennial renewal to support the Steven M. Thompson Physician Corps Loan Repayment Program. It would also require 15 percent of the funds collected from the additional $50 fee to be dedicated to loan assistance for physicians who agree to practice in geriatric care settings.

SB 1379 (Ducheny) deposits fines and penalties assessed on healthcare service plans by the Department of Managed Health Care into the Medically Underserved Account for Physicians, which supports the Steven M. Thompson Physicians Corps Loan Repayment Program. This is competing with AB 2439.

Assistant Director Sullivan stated that OSHPD's opposition to the bill stems from fatal flaws in the language. Currently the bill would require that OSHPD pay for the IOR services through the existing hospital surcharge which is capped and could not support the cost. "There are approximately 600 IORs currently working and OSHPD's Facilities Development Division has approximately 275 employees and a 35 million dollar budget. Even if you double that to 70 million, it would be a very expensive undertaking for OSHPD to get involved in hiring the Inspector of Record."

Director Carlisle added that it is out of the norm for OSHPD to take a position on legislation until it has been reviewed by the Governor's office. AB 2966 is an exception being made at the direction of the Governor's office.

Commissioner Karkia asked if it is cost effective to collect the fee required in AB 2439. "How much does it cost to manage, charge and administer such a program? Could it cost us 300 dollars to collect a 50 dollar fee from the physicians?"

Assistant Director Sullivan stated that the 50 dollar fee would generate approximately three million dollars with a cost ratio at the Foundation of roughly 20 percent of the revenue for overhead costs.

Presentation on use of Hazards U.S. (HAZUS program to re-evaluate hospitals' earthquake performance categories: John Gillengerten, Deputy Director, Facilities Development Division

Prior to 1971 and the San Fernando earthquake, hospitals were designed to commercial building standards. Hospitals were checked by the local building department. The performance of hospitals in the San Fernando earthquake was very poor and there were widespread failures of new buildings. Building failures were attributed to poor design, poor construction and obsolete building codes.

The response to the aftermath of the San Fernando earthquake was the Hospital Seismic Safety Act (HSSA) of 1973 which requires hospitals structure to be sound and capable of providing services to the public after an earthquake. Another function of the

HSSA was to move the authority as building official for construction from local to State jurisdiction.

The HSSA covers all aspects of healthcare construction, the plan review of drawings, the observation of construction to make sure that the building is constructed within accordance with the approved drawings and building codes.

The Facilities Development Division (FDD) within OSHPD has six primary areas of responsibility:

- Plan review and construction observation
- Regulation development
- Hospital Seismic Retrofit Program
- Hospital Building Safety Board
- Research
- Emergency Response

FDD's plan review efforts are unique in that they are thorough and produce the best performing buildings in the country. Staff check for code compliance, examine the drawings and during construction, observe the construction to ensure that it is executed in accordance with the plans. A unique aspect of healthcare construction is continuous, full time inspection of the project site while work is being done and FDD staff monitors the work of the Inspector of Record.

Healthcare construction in California is currently at $19.4 billion dollars for 2008 up from the $5.9 billion spent on healthcare construction in 2000. The large run-up in healthcare construction is largely due to the aging infrastructure and the seismic mandate with its deadline of 2013. The Northridge earthquake and the resulting Senate Bill 1953 were the catalysts for the majority of this construction.

The SB 1953 program classified every building in the State by risk, with a "1" being the worse and "5" the best. Two aspects of the buildings are examined: structural performance, which is the probability that it might collapse in a major earthquake and nonstructural performance, which addresses the functionality of the various systems. Hospitals are complex buildings and in order for them to function, not only must they remain standing, but all of the systems from the ventilation system and plumbing system to the medical gas and equipment must be in working order.

FDD evaluated every hospital building in the State, including new construction, and approximately 2,600 buildings were in the worst performance category, SBC-1. That represents about 40 percent of the building inventory of the State. The average age of these buildings is about 54 years. The Rand Corporation believes the useful life of a hospital is 50 years. The average hospital is comprised of five buildings, and hospitals evolve over time, with additions being added around the original structure. This situation, "the apple with the worm in it" is to a large extent why renewal of infrastructure is so difficult and costly as the central location of older buildings makes them difficult to work on.

Hazards U.S. (HAZUS):

- HAZUS is a standardized earthquake loss estimation methodology developed by FEMA
- HAZUS is being used to re-evaluate the relative seismic risk of the most hazardous (SPC-1)
- HAZUS will reduce the number of buildings to be replaced, retrofitted or removed from acute care service by the 2013 deadline
    - More than 50% of the SPC-1 buildings could be reclassified as SPC-2, delaying compliance until 2030

HAZUS is GIS-based. It defines a geographical area and a specific hazard upon which existing building inventory is overlaid. HAZUS can then be used to evaluate many kinds of natural disasters including flood, fire and earthquake. It can estimate the damage and, taken to the ultimate level, estimate the casualties. It will also estimate both the needs and the losses that a community will have following an event such as an earthquake.

The areas that are at greatest risk for earthquakes are San Francisco and the Los Angeles metropolitan area and HAZUS shows this more completely and elegantly than has been previously possible.

Review of proposed regulatory changes to update data elements for California Coronary Artery Bypass Graft (CABG) Outcomes Reporting Program (CCORP):
Joseph Parker, PhD, Director, Healthcare Outcomes Center

The CCORP works in conjunction with a Clinical Advisory panel that advises the Office on which data elements to collect and how to report heart bypass surgery outcomes. The panel is comprised of nine members that include four practicing surgeons that meet three times a year. The majority of the data elements that are collected as part of the CCORP come from the National Society of Thoracic Surgeons (NSTS). About 80 percent of the hospitals in California belong to that Society and have been collecting this data for many years. This is the data that hospitals use to compare their own surgeon and hospital level comparisons to national benchmarks.

Early on in CCORP the decision was made to use the same data elements and definition used by the NSTS to do the reporting on risk-adjusted outcomes. Two benefits from that decision are that hospitals don't have to do things two different ways and CCORP outcomes are comparable to the national figures.

OSHPD is proposing to change current CCORP data reporting requirements. All the revisions are in line with the NSTS with one exception, whether the left anterior descending artery was bypassed. OSHPD and the clinical panel feel this data element is essential to provide a more accurate assessment of usage rates for the internal mammary artery, an important process of care measure.

In the regulation package presented to the Commissioners there were 27 new data elements; 27 data elements that have been changed or modified (modifications initiated

by the NSTS), and a number of data elements that were considered to be of little value in predicting mortality have been dropped. There are also some data elements being included to enable the Office to provide risk-adjusted mortality ratings and quality rating for non-isolated CABG surgery. Some of the new data elements OSHPD is asking for will be used in risk models for complications of CABG surgery, including prolonged ventilation, deep sternal wound infection, and post-operative stroke. All of these changes account for an overall increase from 51 data elements to approximately 81 data elements.

The Clinical Advisory panel is required by Statute to approve all data element changes and that was accomplished at the panel's January meeting. OSHPD wants to have these regulations in place for fall reporting.

After some discussion, Commissioner Royer moved to approve the regulatory changes to the CABG data reporting requirements and Commissioner Greenfield seconded the motion. The motion unanimously passed.

Summary Report on suggestions received from facilities regarding definitions of possible new patient-level data elements: Starla Ledbetter, Data Projects Manager

Manager Ledbetter outlined a number of tasks relating to the addition of data elements to the patient level data sets including participating in the annual Hospital Cost and Utilization Project, obtaining clinical data element definitions from Cardinal Health and staff meetings with the California Department of Public Health (CDPH) staff on lab standards.

Staff is currently working on a business case for address and for the operating physician ID. One of the issues surrounding address is looking at if staff can get the address to come in to the MIRCal system, have it geo-coded or somehow add a location indicator up front, and then not store the patient address on the database.

Manager Ledbetter stated that at the last several meetings she had talked about a survey that was going to be sent to 448 hospitals regarding the proposed clinical data elements. The survey was extensive and contained questions covering items such as hospital agreement with staff definitions and format, whether hospitals currently capture data elements electronically versus on paper, estimates of costs for reporting, and the status of implementing the electronic health record. Staff has received 164 surveys which represents approximately a 44 percent return rate.

Manager Ledbetter presented some of the main areas of the survey's findings:

- 80 to 90 percent of the facilities agreed with the definitions for lab values and units of measure.
- Only 2 facilities are using Logical Observation Identifiers Names and Codes (LOINC) which is a standard way of transmitting lab results between systems.
- Facilities agreed with the proposed definitions, reporting units and format for vital signs.

- 72 percent of the facilities collected secondary address which includes apartment number and suite number in addition to street address.
- 70 percent of the facilities collected the name of the country for patients residing outside of the United States.
- 80 percent of the facilities said they did not know when they would implement the electronic health record and 16 percent said they would implement electronic health record in the next five years. Over 50 percent of the facilities are operating with a type of hybrid medical record, with electronic lab systems and the remainder a paper system.
- 70 percent of the facilities stated that they do capture the name of the facility transferred from, and 85 percent the facility transferred to.

Commissioner Fine stated that with regard to format there is not enough room provided to indicate marked abnormalities. "For AST, normally it would be a two-digit number, but in someone with a problem, it could be a three- or four-digit number. Have you accounted for this in your database?"

Manager Ledbetter stated that feedback on this issue was not received from facilities surveyed.

Dr. Parker stated that staff will need to look further "at the possible ranges, and not just the normal ranges."

Manager Ledbetter stated that some of the facilities were concerned about the cost of abstracting the data and sending it to OSHPD as is not currently stored electronically, as is the case with vital signs which are still reported on paper. Facilities are also concerned about the cost of the system changes and they requested at least one year lead time to implement some of these changes. Facilities also want the purpose and use of each of the data elements clearly stated.

66 percent of the facilities recommended phasing in the data elements over time and that OSHPD allow them to order how they would like to see this happen. "Their preferred order collection was patient address, then operating physician ID, then lab signs, and then vital signs." At this point there are a number of data elements being considered and "we hope to, when we come back to the August meeting, actually have some recommendations for you to take action on."

Chairperson Genna asked if a motion was needed pertaining to the findings that suggest "hospitals are saying that they would rather see a phased-in approach…"

Manager Ledbetter stated that at this point staff does not need a motion to that effect and Commissioner Fine added that, "we can probably make the motion when we have the full recommendations, and include the phasing-in as part of that motion."

Dr. Carlisle added that, "I would keep in mind that this perspective only takes into consideration the sense from the entities that would be reporting the information. It is not a survey of the people who would benefit from the reporting of this information. If we

surveyed others about how useful this information might be, they might have a different sense about the phasing-in of the data reporting."

Commissioner Fine suggested that input from the researchers who would use this information is needed and Dr. Parker agreed, stating that at the upcoming AB 524 Technical Advisory Committee (TAC) meeting the list of recommendations would be discussed and the Committee's input incorporated.

Report on recent changes in licensing of physician-owned ambulatory surgery centers, including potential scope of impact on data reporting in OSHPD by ambulatory surgery clinics: Robyn Strong, AGPA

Ms. Strong was asked to come to the CHPDAC meeting to answer a question regarding a recent court ruling that occurred and how its effect on the licensure of surgical clinics will affect OSHPD and its data.

Background information:

Dr. Daniel Capen filed a complaint in 2002 against what was, at that time, the Department of Health Services because they would not permit him to operate a clinic under the ownership and management arrangement that he desired without first obtaining a license. He alleged that the Department's opinion was underground regulation requiring him to have a license to operate his clinic.

The case went through several court hearings and rehearings. According to the current status, as of September 2007, there was an opinion on the rehearing, filed by the court that did find that they considered this to be underground regulation and that because this was a physician ownership situation this did not come under the jurisdiction of the Department of Public Health (formerly part of the Department of Health Services).

Because of this ruling, the Department of Public Health has been told that they cannot enforce a certain level of physician ownership. If it is a physician owner, it would come under the Medical Board.

"There is potential for future change in this decision regarding the licensure of the surgical clinics. Where we are now, with the Department of Public Health, is they have chosen not to identify the surgical clinics that are physician owned en masse. They are identifying them on a one-by-one basis, as they come up for renewal and at that time sending them a letter advising them that they have been de-licensed because of this court ruling, and that their current license is null and void, and that their renewal license will not be granted."

How this impacts OSHPD:

OSHPD's authority for both the MIRCal system and accounting and reporting utilization reports is to collect data from, among others, licensed surgical clinics. If they no longer have a license, OSHPD's authority is gone with respect to those clinics.

Currently 13 facilities have submitted documentation stating that they are no longer licensed. OSHPD has given facilities the option to continue submitting data, but of those 13 facilities only one has opted to continue submissions. The California Ambulatory Surgery Association (CASA) has expressed the opinion that they want to encourage their members to continue submitting data.

Commissioner Greenfield stated that CASA has sent a letter to all of its members, strongly urging them to continue submitting data. "Is it possible for CASA to get a list of who is opting out, and especially if they are CASA members?"

Chief Legal Counsel Wied indicated that she did not see any privacy issue as this is public information and Commissioner Greenfield could contact her for the information.

Looking ahead, OSHPD staff has forecasts a loss of approximately 54 percent of the facilities which produced about 64 percent of the ambulatory surgery data records submitted to MIRCal in 2007. This is a significant impact on the data collected in addition to the loss of $361,000 in fees to the Data Fund.

"As far as OSHPD's accounting and reporting section, the 2007 utilization reports came in February of 2008. As staff learns of de-licensed facilities, due to the Capen decision, they are updating their system with an expiration date of the September 19th, 2007 ruling date."

Report from Healthcare Outcomes Center: Joseph Parker, PhD, Director, Healthcare Outcomes Center

Merry Holiday-Hanson, PhD has joined OSHPD as the new manager of the Administrative Data Program Unit. Ms. Holiday-Hanson comes to OSHPD from the Food and Safety Branch of DPH and has a variety of experience in government.

The Office is very pleased to see a drop in the mortality rate for isolated coronary artery bypass graft surgery (CABG) from 3.1 percent in 2005 to 2.2 percent in 2006. UCD researchers are currently doing a study to try to understand whether this is related in any way to patient selection or other variables, in an effort to assess the impact of the public reporting program. But as a caveat to this trend it should be noted that there was a 10 percent decline in the volume of isolated CABG surgeries being performed during that same period. This decline in volume seems to be flattening out in 2007.

Dr. Carlisle added that "after several years of a plateau in the mortality rate for coronary artery bypass graft surgery, with the advent of mandatory public reporting, we are now seeing a 30 some percent reduction in CABG mortality rate after risk adjustment. It corresponds, of course, to a decline in the utilization of CABG, but does not seem to result from surgeon selection of less severely ill patients. This is a huge and very dramatic effect…and if it bears up under additional scrutiny, it represents a landmark in public reporting of outcomes data."

The Patient Discharge Data Validation Study conducted by Dr. Andrew Bindman has been completed on schedule and is being reviewed by OSHPD staff. Dr. Bindman would

like to do some additional validation of the coding of present on admission, using physicians. In the current study researchers used health information technologists and registered nurses. No contract extension has been granted at this time. Dr. Bindman will present the results of this study at the August 7th AB 524 Technical Advisory Committee (TAC) meeting.

Staff gave a presentation on the AHRQ Patient Safety Indicators (PSIs) to the TAC at the June meeting and have subsequently given the presentation to the California Hospital Association's Quality Committee and the California Hospital Assessment (CHA) and Reporting Task Force (CHART) due to the high interest in the subject.

The National Quality Forum (NQF) endorsed seven of the PSIs and five of the in-patient mortality indicators in addition to 45 other measures. Because of their endorsement by NQF, staff is now evaluating the AHRQ in-patient mortality indicators. Approximately seven of these relate to risk-adjusted outcomes for procedures and three of these relate to risk-adjusted mortality for patient conditions.

OSHPD has not historically been supportive of these measures from AHRQ as their methodology did not include present on admission (POA). AHRQ has made some changes to this methodology which included the addition of POA. Staff have done some internal validation of AHRQ's measures and found that that AHRQ measure that includes POA coding yields results more similar to the Office's clinical CABG gold standard than the AHRQ measure without POA information.

Commissioner Karkia observed that at the last CHPDAC meeting a performance audit to follow the patient safety indicators was discussed and he asked if staff see any future possibility that every hospital or facility can implement the software by which they could follow the indicators, automatically update information to OSHPD and get feedback on how they are doing. Commissioner Karkia added that he would like to go on record as requesting that this be a topic "to follow in the future; the monitoring of indicators for quality as well as risk-adjustment.

Dr. Parker stated that if the Office decides to go forward "and we have the support of our various committees, these numbers can be generated fairly quickly. For example, probably within a month or two of the 2007 OSHPD patient discharge data coming online, we would have their actual results and we would be able to publish their results."

Report on preliminary staff analysis of risk factors for in-hospital mortality, including patient demographics, high risk medical conditions, and end-of-life orders (DNR vs palliative care): Mary Tran, PhD, Retired Annuitant

Dr. Tran reported that this analysis was conducted to characterize hospital patients most likely to die in the hospital, identify medical conditions with the highest death rates, and compare death rates for patients with different end-of-life preferences in their records.

Summary of preliminary findings:

- In the statewide population, in-hospital deaths accounted for twice as many deaths in children as in adults.
- Risk of death increased 20 percent per decade of age and about 20 percent for each race/ethnicity other than white.
- Risk was greater for:
    - Patients paying for their own care (OR=1.7) or using Medi-Cal (OR=1.6), compared with patients covered by private insurance.
    - Patients admitted for palliative care (OR=43) or with DNR (OR=6.5).
- After controlling for age, race/ethnicity, payer, and end-of-life preference, risk of in-hospital death was greater for patients admitted with:
    - Septicemia (OR=40+)
    - Liver (OR=4.5)
    - Cancer, Stroke (OR=2.5)

Additional Study Needed:

Child deaths

- Over 80 percent of the child deaths had a principal diagnosis of liveborn (CCS code=218). Further study of these cases is needed to identify (1) the conditions and complications reported in the secondary diagnosis fields of these cases and (2) any related demographic patterns.

Infections

- Cases with principal diagnosis ICD-9 codes related to infection (sepsis, infection, and septicemia) are included within several of the high mortality risk CCS groups. Further study is needed to extract these cases from their larger code groups and clarify their contribution to mortality in patients hospitalized for chronic diseases and complications of devices and implants.

Chairperson Genna asked whether future analyses could break down the senior age group into 65 to 84 and 85 and above.

Dr. Tran agreed that this could be incorporated in future analyses.

Director Carlisle commented with regard to payer types, “We do not have a severity adjuster here, apart from the type of condition that the patient presents with, or the end-of-life preference. But this may actually be a proxy measure for severity; patients that are self-pay, other pay, or Medi-Cal may present with more severe illness, perhaps due to lack of access to care before they come to the hospital.”

Chairperson Genna added that this seems to be the case from the long-term care side. “People who have gone back and forth to the hospital and have been in nursing facilities for a couple of years, quality of life becomes a real issue. If there is very little quality of life, the private paying person seems to be able to make a conscious decision quicker.”

Dr. Parker stated that it would not be difficult to put a severity of illness adjuster such as the Charlson Morbidity Index in the analysis.

Commissioner Karkia asked how the information contained in this report could be used "to come up with a health master plan for the State of California and would lead to preventive maintenance from the health point of view."

Director Carlisle stated that there is a report on preventable hospitalization which is approaching completion. "These are conditions where thousands and thousands of Californians are admitted to the hospital for situations that should be, essentially, preventable with very good ambulatory care." This report allows the counties that are hot spots in a county to be identified and "gives them a population-based indicator that there may be challenges with access and quality of ambulatory care in those counties."

Next Meeting: The next meeting will be held on August 22, 2008 in Sacramento, California.

Adjournment: The meeting adjourned at 1:50 p.m.

Pending Items:

1. Report to the Commission on the implications and feasibility of adding the "Identification of Transferring Facility" variable at the June meeting.

2. Commissioner Karkia requests a special session of the CHPDAC to discuss various issues pertaining to the functions of the Commission.